

Filing a Complaint

What are your rights?

You have a right to expect a professional standard of conduct from a licensed ophthalmic dispenser (optician). If you believe an ophthalmic dispenser has violated Kentucky statutes or regulations, you may send a written complaint to the Kentucky Board of Ophthalmic Dispensers. As the body responsible for regulating the optician profession and protecting the public in matters related to ophthalmic dispensing, the Board will review your complaint and take appropriate action.

How does the complaint process work?

Complaints that have been received in writing at the Board office will be acknowledged immediately by letter. A copy of the complaint will be forwarded to the individual and he/she will be given twenty (20) days to respond. The complaint and response will then be reviewed by the Board members at their next meeting. If no law appears to have been broken, you will receive notification from the Board. If the Board believes a law may have been broken, an investigation will take place. If the Board files formal charges against an ophthalmic dispenser as a result of the investigation, an administrative hearing may be held. This formal hearing involves lawyers, a court reporter, a hearing officer and witnesses. If the Board finds that the ophthalmic dispenser has not met the prescribed standard of conduct, it has the authority to impose penalties ranging from suspension or loss of a license to a reprimand. A penalty may be reached by agreement between the Board and the ophthalmic dispenser.

What might I expect from filing a complaint?

The complaint process is a detailed and careful one, and you should expect some delay. In every case the ophthalmic dispenser will be informed that a complaint has been filed, the name of the complainant, and the disposition of the complaint. Not every complaint results in disciplinary action by the Board if the individual has not violated the laws governing this profession. If charges are filed, a hearing may be held similar to a court trial, and it is open to the public. You may be subpoenaed as a witness to provide testimony regarding the case. In this event the Assistant Attorney General assigned to the Board will assist you in preparing for the hearing. If the Board orders a specific sanction, the individual has the right to appeal, and a final decision may be delayed in the courts. While you may have an opinion regarding the process and outcome of processing your complaint, please remember that the decisions to dismiss or settle a case or propose disciplinary measures are solely the decision of the Board and may be subject to review by the courts.

If the Board files formal charges or takes formal action against a ophthalmic dispenser, most portions of the investigative file will become "public record" which can be viewed by any individual who requests, in writing, to do so. The record may include your written complaint, transcripts, or reports of interviews, letters, and other reports. All testimony and evidence admitted in a formal hearing have the status of public record as well. Patient records obtained in the process of investigation usually can be protected from disclosure as public records.

Throughout the various stages of the complaint process, you will be kept informed. You will also be advised of the final outcome.

How do I make a complaint?

You should complete the complaint form that accompanies this information sheet. Make sure you give all pertinent information. Please sign the complaint form so that the Board may look further into your concerns. If your complaint refers to treatment of a specific patient, the patient must sign the "Client Agreement to Release Information" form as well. Complaints and release forms should be mailed to:

KENTUCKY BOARD OF OPHTHALMIC DISPENSING
PO BOX 1360
FRANKFORT, KY 40602

DATE RECEIVED: _____

COMPLAINT NO.: _____

KENTUCKY BOARD OF OPHTHALMIC DISPENSING
Complaint Form

Person Filing Complaint

Name: _____

Address: _____ City: _____ State: _____ Zip Code _____

Day Telephone: (____) _____ Evening Telephone: (____) _____

Name of Ophthalmic Dispenser

Name: _____

Business Name: _____

City: _____ State: _____ Zip Code _____

Day Telephone: (____) _____

Name of Patient
(if applicable)

Name: _____

Address: _____ City: _____ State: _____ Zip Code _____

Day Telephone: (____) _____ Evening Telephone (____) _____

Relationship to person filing complaint:

Name and phone number of any persons who may provide additional information

1. Name _____ Telephone: (____) _____ Type of Information _____

2. Name _____ Telephone: (____) _____ Type of Information _____

3. Name _____ Telephone: (____) _____ Type of Information _____

4. Name _____ Telephone: (____) _____ Type of Information _____

(Please be as specific as possible regarding names, dates locations, and actions which you believe to be improper, unethical or unprofessional.) Please attach copies of any documents or records pertinent to your complaint.

This image shows a blank sheet of white paper with horizontal black lines. There are 20 thin lines in total, spaced evenly apart. Two of these lines are thicker than the others, serving as margins. One thick line is located approximately one-fifth of the way down from the top edge, and the other is located approximately four-fifths of the way down from the top edge. The rest of the lines are uniform in thickness.

Signature: _____ Date: _____

Send to: BOARD OF OPHTHALMIC DISPENSING
PO BOX 1360
FRANKFORT KY 40602-1360

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Full Legal Name: _____ Address: _____

Date of Birth: _____ Social Security #: _____ Medical Record # _____ Telephone: _____

I, the undersigned, hereby authorize _____ to use or disclose my health information, as described below, to the Kentucky Board of Ophthalmic Dispensers or any authorized agent or investigator of the Board.

I authorize **the Board** to obtain my health information, as described below, from (name or names of health care provider):

_____.

The information to be used or disclosed includes the following specified information:

All Medical Records maintained by the health care provider(s) named above during approximate time period from _____ to _____ including information related to my identity, diagnosis, prognosis and/or treatment, any and all medical and vision records, billing information, and medical and vision reports from the above named Licensed Ophthalmic Dispenser and other health care providers.

I understand that the above records may be used by the Board in the investigation and possible disciplinary prosecution under KRS Chapter 326 against the ophthalmic dispenser. A photocopy of this authorization shall be deemed effective as an original. This release is being executed in the context of health oversight activities and administrative proceedings by the Kentucky Board of Ophthalmic Dispensers. As such, this disclosure is permitted under 45 C.F.R. Section 164.512(a), (d), and (e), the regulations implementing the Health Insurance Portability and Accountability Act ("HIPAA"). The Board will make reasonable efforts to protect the confidentiality of these records under KRS Chapter 61 and Chapter KRS 13B, or other applicable law.

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. However, the recipient may be prohibited from disclosing any substance abuse information under the federal confidentiality requirements for alcohol and drug abuse patient records and the Public Health Service Act. Such information may not be used to criminally investigate or prosecute any alcohol or drug patient. Further, state law prohibits a recipient from making any further disclosure of test results relating to HIV or AIDS without the specific written consent of the person to whom such information pertains. A general authorization for the release of medical or other information is NOT sufficient for such purpose.

This authorization will expire upon the occurrence of the following event or condition: _____. If no event or condition is listed, it will expire in **60 days**. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to the health care provider. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I should keep a copy of this Authorization form, after signing it.

Signature of Patient/Authorized Representative (include relationship or nature of authority)

Date

Signature of Witness

Date